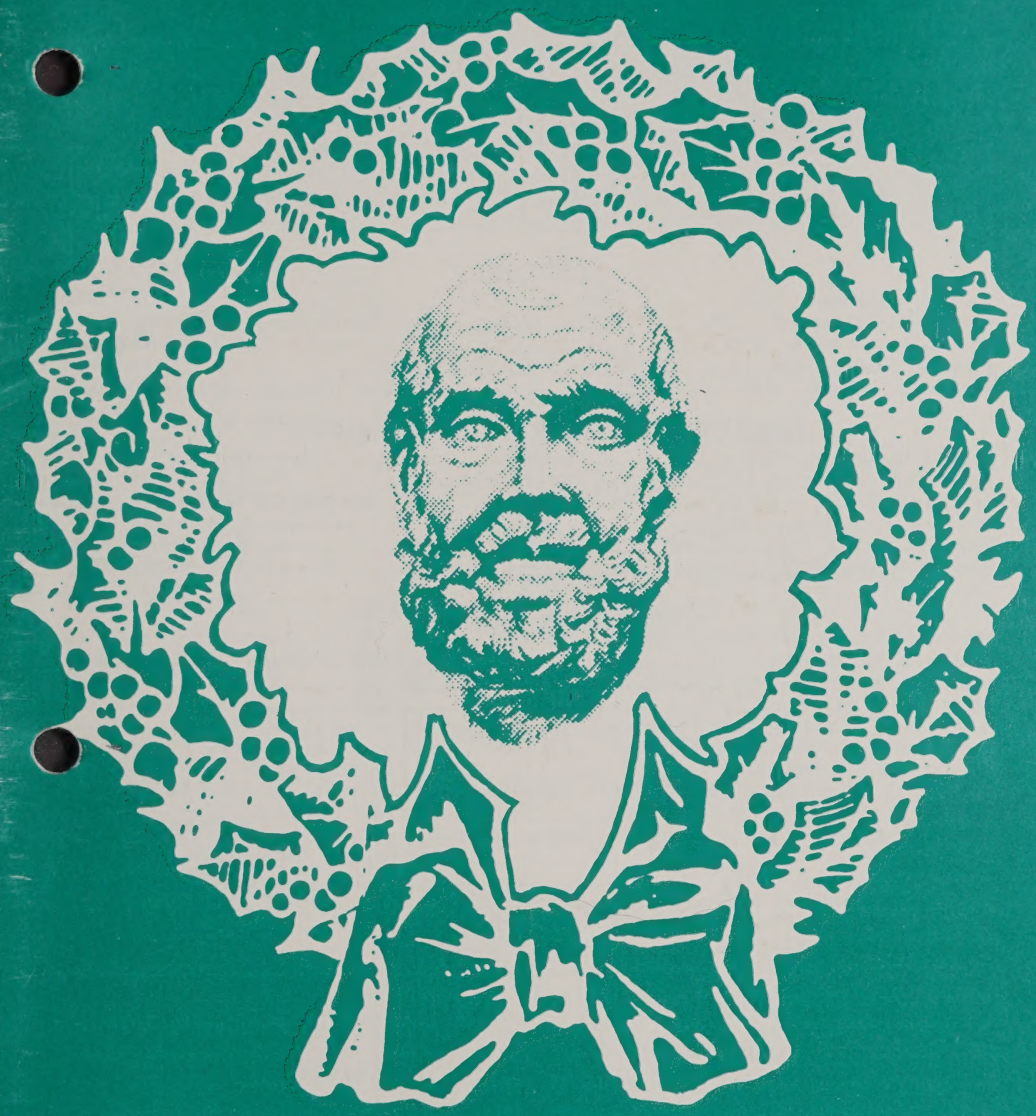

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1942

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Editorial . . .

GOD, SUPER ALL!

Of late, the public image or the charisma of physicians has been retrogressing rapidly. Witness the many, widespread, repetitious, derogatory portrayals in and by the various media of mass communications. Contrary to this vocal minority, virtually all physicians must be good men and women, for why else would they have chosen a life dedicated to the service of their fellow men. Perhaps, this is merely a projection of a universal distress afflicting all of society. Perhaps, all and especially physicians, need to rediscover and reaffirm within themselves the oldest principle that gives life depth and meaning, namely love of God and love for one another.

In today's materialistic world, there are many who do not believe that life has any meaning or purpose. In pursuit of happiness, today's man seems to be placing money, prominence, influence, and power above the transcendent. The scientific method is being extolled as being omniscient and universally relevant, and God is nothing more than a myth.

SERVICE

Caught up in this head-long, turbulent, purposeless flight to no-where but self-destruction, we physicians especially must re-evaluate our roles in this onrushing age. To do so, we must look back before we go foreward. Throughout history and more recently, our profession has had a position of privilege in society only because our fellowmen have had to depend on us for an essential element of life, namely, physical and mental well-being. As such, our privileges were and are not accorded to us as individuals but as a profession with knowledge and skills belonging to the community rather than to ourselves as individuals. Our community needs this knowledge and these skills if the common good is to be maintained and hence, has a right to these services. We in the profession merely hold in trust these skills and this knowledge for the service of our fellowmen. And yet at times we act as though "entry into the profession has brought us into a heritage of possession rather than a posture of service." Moreover, in the "pecking order" of medical hierarchy, personal pride must not be placed above personal service. Our responsibility for protecting the life and well-being of others is a deep one. We must discharge it as we see it in the light of our expert knowledge and proved guidelines and in honesty with ourselves, ever keeping in mind that it is a responsibility of service and not a prerogative of ownership.

PERSONAL INTEGRITY

In the past decade, there seems to have been a shift in the basic orientation of American mores, wherein there is a primary concern for the group rather than for the individual. The approach has shifted from *him* to *them* with proponents viewing this as a necessary step toward equal opportunity for all. The sociological merits of such a shift may be good; however, the moral "spin off" as manifested in shifting personal integrity to social integrity has dire forebodings. This shift in moral emphasis is reflected in the widespread conviction that whatever a man does with, for, or to himself is of no moral significance and that an act is morally good or bad only in its social impact. A deep sense of social responsibility is most important; however, if same results in a decrease of personal integrity, then we are in a self-defeating proposition.

In our fervor to embrace the most modern, we physicians seem to have forgotten that leadership is a very personal thing. There is no special scheme nor guide needed to restore physicians to their place as trusted advisors, healers, and friends but a show of personal integrity and faith in God. Can we accept individual man stripped of purpose, meaning, individuality, and God? Let us not just live our own selfish and protected lives and make decisions on the basis of expediency, but rather let us cultivate personal integrity through discipline, reason, perceptiveness, and imagination with a firm belief in the transcendent. Social integrity can only find its balance in and with personal integrity.

Let us activate our love of God and our love for one another again and again with an ingenuity to match our onrushing age. Let us ever keep in mind the insight into human nature as enunciated in the parable of the sower by the humble Galilean ever seeking to better the human lot. The winning combination can only be the combining of old truths and wisdoms with those of today under the guidance of God.

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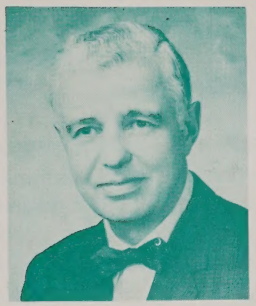

President's Page

THE CLERIC AND THE MEDIC

During the past several years the December issue of *The Hampden Hippocrat* has been devoted to subjects concerning medical, religious, ethics and discipline. Our editors should be complimented for their interest in this field of medico-religious subjects. In our very hectic every day experiences, surrounded by all kinds of "scientific" reports, gadgets, and computers delineating patho-psysiological status of the patient, we sometimes loose sight of the "soul" of the patient. This is typically seen in the intensive care unit of a well managed hospital. It is so very comforting for the patient when his clergyman comes to visit him. The clergyman's task in turn is made somewhat easier when we, the men of science, inform him of some of the medical problems. So often, when the patient is depressed because of the diagnosis of say cancer or heart disease, he snaps out of his depression following a chat with his clergyman. The joint ministration of the patient by his clergyman and his doctor is the concept of treating the patient as a whole being.

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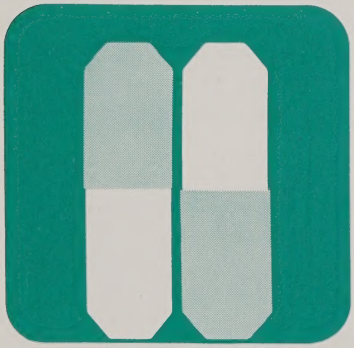

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TOTAL PATIENT CARE

by
Garry deN. Hough, III, M.D., Chairman,
MMS Committee on Medicine and Religion

Regardless of the benefits of specialization for both patient and physician, the consequent fragmentation of medical care is a detriment of almost equal magnitude. Always a danger to the morbidity and mortality of individual patients, fragmentation is one of the major characteristics of modern medicine inciting a desire for radical change in the American health system. The first and perhaps, the most serious division came when the priest-physician divided his client into body and soul. Western Christianity sanctified this dichotomy, and healing of the body gradually evolved into scientific medicine; whereas, salvation of the soul remained a metaphysical undertaking.

Several recent studies may assist in removing this schism. Mason et all report a highly positive correlation between healing rate in surgery for retinal detachment and the "acceptance rating" of the patient. This rating was developed by the chaplains at New York Presbyterian Hospital but applied by five people of varying sophistication. Ten categories were used to evaluate the patient's reaction to his illness, his surgeon, his operation, his environment, and his future. Retinal repigmentation could be predicted reliably bv this index. Casual relationship is carefully disclaimed but "speed of healing and acceptance level are twin descriptive aspects of the patient's total response to danger". Religiousness alone was poorly predictive, but a "reverential trust in life" augered rapid healing.

More conventional standards were used by Comstock (2). He reported a strong correlation between death rates from heart disease and church attendance in 567 Caucasian males, age 45 to 65, in Washington Co., Md. The risk of fatal heart disease was almost twice as great in men attending church less than weekly, a more marked association than any factor studied, including water hardness (the primary focus of the study), cooking fuel, years of schooling or current use of cigarettes.

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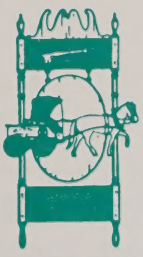

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The most obvious interface between medicine and religion has been codified by the interdisciplinary seminar on death and dying at the University of Chicago's Billings Hospital. The story of Dr. Elizabeth Kubler-Ross's (3) effort to overcome the hostility of physicians and nurses to establish communication with terminal patients is almost more interesting than results. She has isolated five steps of maturation in facing death: denial, resentment, bargaining, depression, and acceptance. Her book illuminates a dark corner of medical practice and shows how physicians can provide help when it is needed most.

These three publications illustrate positive programs in physician-clergy cooperation. "Unfortunately most of us talk a great deal about total patient care (but) show little evidence of believing in it. We seem quite content to deal with a patient as if the only thing that mattered was the welfare of the body, if we are doctors, or of the spirit, if we are clergy. We do, of course, tip our hats to each other as a gesture of courtesy, and sentimentalize about the importance of both and then go right on as we were before preoccupied with laboratory findings, the mechanics or surgery, stomping, out disease (4)". A scientific basis for a level of medical practice better than this may be forthcoming.

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JEWISH ATTITUDES TOWARD CURRENT MEDICO-RELIGIOUS PROBLEMS

by
RABBI DAVID I. SHEINKOPF
BETH ISRAEL SYNAGOGUE
SPRINGFIELD, MASS.

Medicine has always been an integral part of the religion of Israel. The administration of Mosaic laws governing circumcision, physical secretions, forbidden foods, and contagious maladies, certainly presupposed a fund of medical knowledge. The great medical historian, Karl Sudhoff, notes that, "Two of the greatest hygienic thoughts of mankind owe their origin to 'Semitisim' . . .' the weekly day of rest and the direct prophylaxis of disease." Some of the prophets, as well as Jewish priests, practiced the art of healing. And the Rabbis of the Talmud, whose elucidations of the Bible brought the full sum of human life under the ennobling influence of religion, in many instances consulted the physician to assure a just rendering of Jewish law.

In forming an attitude toward medico-religious problems, the Rabbis' regard for the health of the patient was understandably coupled with a search for principles of righteous conduct. Those who ministered to the sick were considered "messengers of God." As executors of God's will, their healing arts could not be separated from the moral implications of their work.

In recent years, five medico-religious issues, which have aroused considerable interest and debate, share one central concern. They each explore the extent to which medical science may be utilized to ameliorate human distress and suffering. Together they focus on the question of what ultimately is the role of the physician. Is his task as a "messenger of God" solely to heal? Or, as his knowledge and technology progress, may he assume such functions which hitherto were readily relinquished to Divine Providence?

For each of these problems, the Orthodox Jewish attitude is summarized below.

CONTRACEPTION AND STERILIZATION

Since in Judaism, the precept of human propagation is not encumbent upon the woman, she is not prohibited from either using contraceptive devices or undergoing a sterilizing treatment when she fears excessive pain or danger in childbirth. Oral contraceptive pills, which may prove hazardous to her health, are to

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be avoided. The husband, on the other hand, is forbidden to use contraceptive safeguards or to submit to surgical treatment which would render his act ineffective.

ABORTION

The claim of nascent and fetal life may be set aside if it poses a definite threat to the mother's life. When, however, the major part of the child is born after a full-term pregnancy, its claim to life is equal to that of the mother and it must not be destroyed. If conclusive proof of a full-term pregnancy is lacking, so that the viability of the child is cast in doubt, then it may be sacrificed to save the mother, should the failure to do so lead to the loss of both lives.

ARTIFICIAL INSEMENATION

Although artificial insemenation with donated semen, does not, in the opinion of most Rabbinic authorities, constitute an act of adultery, or render the child born in this way illegitimate, it is, nevertheless, unanimously condemned on moral grounds. Among the abuses which could conceivably result from its legalization is that a wife, who, in fact, had adulterous relations with another man, might claim that her pregnancy was medically induced. The practice of artificial insemenation could also lead to incestuous marriages since the identity of the children's true progenitor is usually known only to the doctor. When the semen is taken from the husband, the majority of Rabbinic opinion favors a more lenient attitude.

EUTHANASIA

Jewish law, in common with most modern criminal codes, continues to consider euthanasia, or "mercy killing," an act tantamount to murder. At the same time, any factor, such as disturbing noise, which may prolong the patient's agony by keeping him conscious and preventing quick death, is prohibited. Prayers may be offered for the demise of an incurable as a means of securing his release from extreme suffering.

HEART TRANSPLANTS

Apart from the moral problem of hastening the death of the donor by removing his heart, the extraction of the heart of the recipient, defective as that organ may be, deprives his life system of its most vital instrument. The recipient, despite the mechanical means employed to circulate his blood, is no longer "alive" in the normal sense of the term. It is true that in regard to other defective organs, Jewish law sanctions surgical treatment even in cases where the patient's prospects of recovery are slim and the operation itself may prove fatal. However, Rabbinic authorities are reluctant to condone such surgical treatments as heart transplants which not only fail to restore health, and may actually hasten the death of the patient, but also place him in immediate jeopardy by removing from his body the central organ of human life.

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HOW WILL WE HAVE IT?

The great medical debate of the 1960's was concerned with "when to pull the plug" or when did life stop and artificial life support take over. The 1970's has already staged its great debate. This concerns life at the opposite end of time, namely, when does life begin with regard to the great debate over abortion reform. Medicine's latest breakthrough is setting the stage for the great debate of the 1980's. This breakthrough is genetic counselling, with the inevitable followup of genetic manipulation and finally genetic engineering. Although the problems are becoming more clearly defined, their solutions are likely to perplex and divide the medical profession.

The science of genetic counselling in its earliest stages is nothing more than a review and application of Mendel's statistical observations to humans. The science of statistical genetic counselling is simple. The odds are quoted to prospective parents, and they make a choice. No ehtical or moral decision needs to be made, and no conflicts are created. With advancing technology the affected infant can be treated as in the case of P.K.U. With environmental engineering and/or manipulation, the disease process becomes even less important and genetic counselling becomes even less critical. With further technicological advances a new problem is introduced. Aminocentesis and chromosomal studies now enable the physician to diagnose congenital disease in utero. Now genetic counselling offers not only a statistical analysis of the risk, but can tell in many cases the outcome of the parents' decision before birth takes place. With this advance comes the morality of termination of pregnancy and all the ensuing legal, ethical, and religious conflicts. The problem is not completely solved, but with our concept of human rights and with our concern with the quality of life we will strive for a new right, namely that of being born without the handicap of a readily preventable serious genetic defeat. As our knowledge of genetics increases, we surely will not indefinitely accept the invisible hand of blind natural chance. But by decreasing the births of those with genetic limitations, we will strive to improve the genetic pool and increase the supply of those with special talents.

GENETIC ENGINEERING

The next advance will undoubtedly bring forth the ability to transfer genes in the living state. The concept of gene transfer for the cure of hereditary disease will remove the problem of pregnancy termination and will introduce another method for improving the genetic pool. After all, there is little difference between the physician's moral duty to prevent or

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to cure specific hereditary diseases. Once the technique of gene transfer is perfected, the possibility of its extension to any useful control of behavior is introduced. Whether it be a single gene transfer for the cure of a defect, such as diabetes, or a polygenic transfer to control the interesting features of behavior, such as temperament or intellect, we introduce the ethical question of whether we can justify designed genetic changes in man for the sake of both therapeutic and non-therapeutic benefits. Once the difficult technique of polygene transfer is achieved, man is then in a position to blueprint personalities. If we accept blueprinting of personalities as a principle, it would be much easier to achieve the same result by cloning, i.e. producing genetic copies by transfer of a diploid nucleus. Cloning would thus be the ultimate in genetic intervention or genetic engineering, especially since nature has already supplied us with a catalog of 4,000,000,000 patterns.

By now the reader must be aware that science and technology have crossed the line leading from negative eugenics or destructive eugenics of the 1970's to the concept of positive eugenics or constructive eugenics of the 1980's. How can we with our present thinking justify such a new and frightening concept? It is entirely possible, given our present increasing pollution of the human gene pool through uncontrolled sexual reproduction, that we might have to replicate healthy people to compensate for the spread of genetic diseases and to elevate the plus factors available in ordinary reproduction. Over-population could force us to put a stop to the general fecundy of today's world and to resort to laboratory reproduction. If the greatest good of the greatest number of people were served, it could be justifiable. Such willed, chosen, and controlled reproduction certainly is more purposeful than genetic roulette.

How then will the great debate of the 1980's be staged? Will the issue be one of rights versus needs? If medical care can use genetic engineering to protect people from disease or deformity or to ameliorate disease and deformity, is the right to be born more important than the needs of a society to be free of disease and deformity? The right to conceive and bear children has to stop short of knowingly making crippled children, and genetics gives us that knowledge.

Will the issue be one of what is human and what is not human? By cloning we can create a society of top scientists, etc., and then also by cloning and genetic manipulation we can create a society of man-machine hybrids for the dull and unrewarding roles in a community. Are we truly creating a human society? Since the continuance of life no longer depends on hetero sexual coital conception, is this society human?

No one can answer these questions with ease and authority. We will have to call on moralists, physicians, scientists and theologians to join in extensive debate. As our great thinkers analyze the question, our society will not reach any firm decision other than that of the common aim – "the personal improvement of humans". Moreover, if history truly does repeat itself, the problem of misuse will arise – not biological misuse but political misuse.

Zadworny

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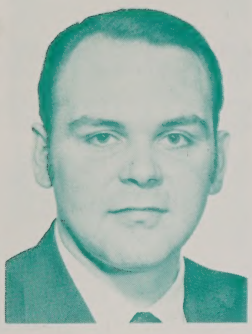
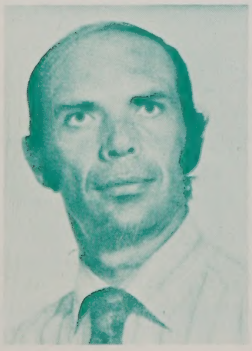


GREGORY J. GALLIVAN, M.D., 130 Maple St., Springfield, Mass.
Born: April 25, 1938
Medical School: Tufts University, 1962
Internship: Hartford Hospital, Conn.
Residency: USPHS Hospital, Staten Island, New York; Hartford Hospital, Conn.; New Britain General Hospital, Conn.; University of Texas, Southwestern Medical School at Dallas.
Specialty: Thoracic Surgery.

VINCENT A. GUARDIONE, M.D., 281 State Street, Springfield, Mass.
Born: March 6, 1938
Medical School: New Jersey College of Medicine, 1964
Internship: Boston City Hospital
Residency: Boston City Hospital
Specialty: Surgery, vascular.

HAROLD EARL HARRIS, JR., M.D., 476 Appleton Street, Holyoke, Mass.
Born: September 19, 1938
Medical School: Northwestern University, Chicago, 1964
Internship: Cleveland Clinic Hospital, Cleveland
Residency: Cleveland Clinic Hospital, Cleveland
Specialty: Otolaryngology.



ALFRED HUTT, M.D., 193 Chestnut St., Holyoke, Mass.
Born: October 27, 1934.
Medical School: State University of New York, Downstate.
Internship: The Queens Hospital, Honolulu, Hawaii
Residency: State University of New York, Downstate Medical Center
Specialty: Opthalmology.

SAMUEL J. MAZZA, M.D., 1767 Northampton St., Holyoke, Mass.
Born: August 3, 1938
Medical School: State University of New York at Syracuse, 1964
Internship: The Genesee Hospital, Rochester, N.Y.
Residency: University of Rochester Medical Center, Rochester, N.Y.
Specialty: Surgery.

ETHAN S. ROFMAN, M.D., Department of Psychiatry, WEstover AFB, Mass.
Born: July 26, 1940
Medical School: College of P & S Columbia University, 1965
Internship: University of Michigan Hospitals, Ann Arbor, Michigan
Residency: Mass. Mental Health Center, Boston, Mass.
Specialty: Psychiatry.

THE NEXT MEETING of the SPRINGFIELD ACADEMY

TUESDAY, JANUARY 11, 1972 at 8:00 P.M.

SPEAKER:	Henry H. Banks, M.D. Professor and Chairman, Department of Orthopedic Surgery Tufts University School of Medicine
TOPIC:	"The Treatment of Cerebral Palsy"
CLINIC:	Shriners Hospital for Crippled Children 5:00 P.M. "General Pediatric Orthopedic Problems"
DINNER:	Storrowton Tavern Cocktails 6:30 P.M. Dinner 7:00 P.M.
RESERVATIONS:	Please call Mrs. Lund (734-5445) before Friday, January 7, 1972

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Section 3 -- describes how you want various types of calls handled: emergencies (bleeding, pain, fever, vomiting, loss of coordination, etc.); routine messages (request for patient information, etc.); nonmedical calls (insurance information, detailmen).

Section 4 -- tells your staff how to handle prescriptions, in- and out-of-office prescription renewals, gives Latin terminology.

Section 5 -- provides a list of important personal callers -- your family, lawyer, accountant, broker, etc. Also lists consultants, pharmacies, laboratories and hospitals that may call you (or that you may call) frequently.

The Message Form

The Rocom Telephone message form is designed to remind your aides to obtain all pertinent information regarding the patient. Equally important, there is space for you to write in your disposition of the call. The message form has a self-adhesive backing so that, if you wish, it can be adhered directly to the patient's permanent record. You write the information only once and it is always available for future need.

The message form comes in two ways: padded, 4 messages to the sheet for use at the switchboard, and padded, 1 messag to the sheet (checkbook style) for you to carry with you.

Telephone System by Rocom

SECTION 2

PRACTICE INFORMATION

OFFICE HOURS (Enter hours in pencil)

Physician & Specialty	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
B.A. Jones	–	–	–	10-12	"	10-12	–
Internist	2-5	2-5	–	2-5	2-5	–	–
E.W. Stuart	10-12	10-12	10-12	–	10-12	10-12	–
INTERNIST	–	–	2-5	–	–	–	–
P.T. Doerr	–	–	–	–	–	10-12	–
Internist	2-5	2-5	2-5	–	2-5	–	–

OFFICE PROCEDURES AND FEES

Procedure	Fee	Procedure	Fee
Routine office visit	$ 10.00		$
Complete Examination	$ 35.00		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$
	$		$

OUT-OF-OFFICE SCHEDULE

Calls often come in when the physician is away from the office. You will be told where he can be reached at all times and you should keep a record of his whereabouts on the following form. He will also tell you who should be given his out-of-office number and when he wants you to relay the message.

In the boxes below, record the hours the physician expects to be at certain place and the phone number where he can be reached. Fill in the information in pencil.

WEEKLY OUT OF OFFICE SCHEDULE

Physician	Monday	Tuesday	Wednesday
Dr. Jones	Mercy Hosp. City Clinic (AM)	Mercy Hosp	Mercy Hosp.
Dr. Stuart	Memorial Hosp	Memorial Hosp City Clinic (PM)	Memorial Hosp
Dr. Doerr	City Clinic (AM)	City Clinic	Med. School City Clinic (PM)
Physician	Thursday	Friday	Saturday
Dr. Jones	Mercy Hosp	Mercy Hosp City Clinic	
Dr. Stuart	Memorial Hosp	Memorial Hosp	
Dr. Doerr	City Clinic (AM)	City Clinic (AM)	

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Date	Date	Time	Who Called		Phone
Patient Name	About Whom		Age	Temp.	Physician
Chart #	Address			Urgent	Call Back
	MESSAGE:		DISPOSITION:		
				Chart ☐	Chart #
	Medication Allergy	Rec'd by:	Handled by:		

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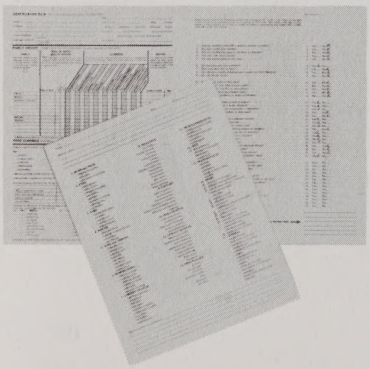

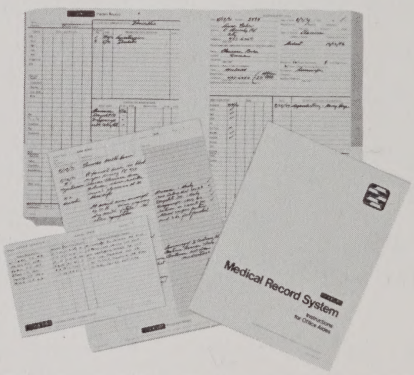

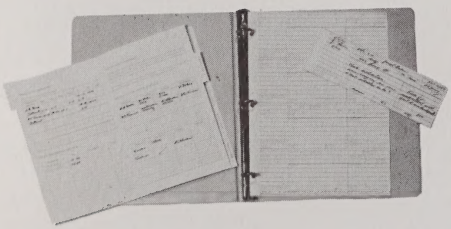

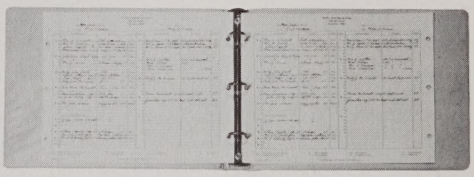

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ROCHE

One Man's Opinion . . .

ETHICS, RUSSIAN STYLE

"None are more hopelessly enslaved than those who falsely believe they are free."
– Goethe

Our codes of ethics, as we all know, are of our own choosing. They embody our philosophy, our prerogatives, and our responsibilities. Political controls, at least as of now, have nothing to do with either their formulation or enforcement.

The same applies to the oaths and pledges taken by our students on graduation from medical school. Some schools cling to the original *Oath of Hippocrates;* others, use an up-dated version of it; while still others improvise their own. Finally, there are a few schools that use no pledges at all.

BEHIND THE "IRON CURTAIN"

It is safe to assume that similar philosophies and practices prevail in most, if not all, civilized countries on this side of the "iron curtain". But what about the other side? Do our colleagues in Russia, for instance, have ehtical guidelines of their own? If so, are they of their own reflection and conviction? The answers to these questions are to be found, in part at least, in the "ukase" or edict issued by the Soviet governmental several months ago. As reported in the *JAMA* of August 9, 1971 (page 834), it reads:

"The Presidium of the Highest Soviet of the USSR signed an order at the Kremlin in Moscow on the 26th of March, 1971, which approved the text of the Oath of Soviet Physicians, orders every physician in the USSR to take this Oath, and prescribes that every graduate from a medical school in the USSR after June 1, 1971 must solemnly take this Oath during graduation ceremonies. The order was signed by the chairman of the Presidium of the Highest Soviet, N. Podgorny and by the Secretary, M. Georgadze." The Oath of Soviet Physicians is as follows:

"Having received the high title of physician and beginning a career in the healing arts, I solemnly swear: to dedicate all my knowledge and all my strength to the care and improvement of human health, to treatment and prevention of disease, and to work conscientiously wherever the interests of the society will require it;

to be always ready to administer medical aid, to treat the patient with care and interest, and to keep professional secrets;

to constantly improve my medical knowledge and diagnostic and therapeutic skill, and to further medical science and

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the practice of medicine by my own work;

to turn, if the interests of my patients will require it, to my professional colleagues for advice and consultation, and to never refuse myself to give advice or help;

to keep and to develop the beneficial traditions of medicine in my country, to conduct all my actions according to the principles of the Communistic morale, to always keep in mind the high calling of the Soviet physician, and the high responsibility I have to my people and to the Soviet government.

I swear to be faithful to this Oath all my life long."

On the surface the Soviet code resembles our own in many ways. Fundamentally, however, the two are worlds apart. Whereas, in the free world the rules of professional conduct are voluntary and self-inspired, in Russia these rules are completely under the thumb of the Kremlin. In other words, behind the "iron curtain", where everything is regimented, medical ethics are no exception. As a result the physician's conduct there is political rather than ethical. The notorious Medvedev affair is a case in point. Professor Z. A. Medvedev, as many may recall, was committed to a mental hospital last year after gaining world renown for his political dissent. His imprisonment was cut short because of international and local protests. What was the psychiatrist's diagnosis in the Medvedev case? Believe it or not it was: "Incipient schizophrenia accompanied by paranoid delusions of reforming society." Commenting editorially on this type of "misuse of psychiatric personnel and institutions to incarcerate political heretics" the *N.Y. Times* (Nov. 19, 1971) concludes:

"At the very least, Moscow's flagrant abuse of this branch of medicine calls for protest by psychiatrists in all free countries. Such action was actually initiated recently by British psychiatrists at Sheffield University. To the degree that Soviet psychiatry has been perverted into an instrument of political repression, it has lost all standing in the outside world."

CAN IT HAPPEN HERE?

Will ethics, Russian style ever invade our shores? Possibly, but if it does it will not be because of communism but because of escalating political intrusion into the field of medicine. Medical guidance in health matters today is systematically ignored or bypassed in a manner undreamed of only a few short years ago. One example is Washington's recent plan, notwithstanding professional opposition, to dismember the NIH by setting up a totally independent cancer agency. Closer to home we find that all we rate in the recent established Connecticut Valley Health Planning Council, is token representation.

But these are only two relatively minor examples of political infringement.

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"What are fears but voices airy? Whispering harm where harm is not."

Wordsworth

In HUMAN RESOURCE INSTITUTE'S new plan for care of the emotionally ill, custodial hospitals, locked wards, punitive staffs, and authoritarian administrative policies have given way to open wards, intensive active treatment, and a more egalitarian hospital community. HRI'S newly constructed cheerful facilities share a basic orientation, the "therapeutic community." The efficacy of group and individual psychotherapy, somatic therapies and behavior therapies is enhanced when utilized within a therapeutic milieu. Rather than being seen as a detour from his main stream of experience, the patient comes to view the hospital as an integral part of his life experiences and one that helps him put together the dislocated and disorganized pieces of his past.

For further information contact: Pattison Esmiol, M.D., Medical Director, 227 Babcock Street, Brookline, Massachusetts 02146

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They are mentioned here only because they are so recent and current. Far more ominous is the portent that before long (shades of Great Britain!) our government may nationalize all the hospitals in the land. However, our ultimate subjugation will come if and when our principles of ethics and graduation pledges are dictated by interests outside our profession. Does this sound far-fetched? We sincerely hope so, but wishful thinking is not enough. In an article entitled "Ethical Aspects of Genetic Controls" *(NEJM,* Sept. 30, 1971 Joseph Fletcher, B.D., S.T.D. writes in part: "I agree with Michael Baram, of M.I.T. who says:

'I do not think scientific peer groups presently have the objectivity or capability to function as coherent and humane social controls . . . Self-enclosed peer groups cannot be entrusted with self-control . . . because our educational system does not foster ethical and interdisciplinary values in professional training.'"

Similar items are appearing with increasing regularity in the literature. They constitute, of course, an open invitation to outside controls. We are fully aware of the many ethical questions posed by biomedical progress. We are also aware of the need of involving theologians, philosophers and social experts in helping us solve these newer problems. This, indeed, is being done on national as well as international levels. But, if we are to avoid the Soviet formula, the final formulation of our codes of ehtics must remain within the bounds of our profession.

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HIGHLIGHTS OF THE NOVEMBER EXECUTIVE COMMITTEE MEETING

The Executive Committee met on Tuesday, November 16, 1971, in the Conference Room of HDMS. Dr. Bandeian called the meeting to order at 8:06 P.M. Present were Drs. Bandeian, Goldberg, Verrilli, Moore, LaMarche, Sheehan, Burke, McHugh, Fisher, Gilchriest, Cummings and Mrs. Purdy.

Absent were Drs. Zacarian and Turner.

The minutes of the October 19, 1971 meeting were approved as read by Dr. Verrilli.

CORRESPONDENCE

Dr. Bandeian read an invitation from Blue Cross to attend a meeting at the Schine Inn on Thursday, November 18, 1971 at 4 P.M. Mr. Henry Jones, President of Blue Cross, is scheduled to speak. Some members will attend this program.

Dr. Gephart wrote to Dr. Bandeian concerning the physician's Blood Bank. This will be referred to the Blood Bank Committee Chairman, Dr. Janes.

The Bay State Health Care Foundation has announced a meeting to be held on December 15, 1971, at the Sheraton Boston Hotel on Foundations for Medical Care. Dr. Brennan, President of this Foundation, would like a good attendance. This is being announced in the latest *Newsletter* to the membership.

OLD BUSINESS

Mr. Atkinson's letter, in answer to Dr. Bandeian's letter, was read. This was accepted as read.

Dr. Izenstein, President of the Professional Staff of the Springfield Hospital Medical Center, answered Dr. Zacarian's letter concerning emergency care of accident cases. He stated that it was the feeling of his Executive Committee that no one hospital should have the responsibility of providing such a service; rather, the HDMS and all

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hospitals in the area should be involved in a cooperative effort. The staff of the Springfield Hospital Medical Center is willing to cooperate.

The problem of Aetna Life Insurance Company and the Travelers using a $25.00 conversion factor for the Mass. Relative Value Study was discussed. The insurance companies have been quoting Dr. Gephart as saying that this $25.00 conversion factor was official. Dr. Gephart has discussed this verbally by phone with a follow-up letter being sent to Dr. Bandeian. Further discussion was tabled until Dr. Gephart's letter is received. A motion was made to the effect that HDMS would like to know why the Insurance Committee of MMS used a different schedule within Boston and out of Boston when the Council voted to use one.

A report of the Blue Shield Professional Service Committee was read and approved. Question No. 3 will be referred to the Committee on Tax Supported Medical Care.

COMMITTEE REPORTS

A report of the Interhospital and Community Health Planning Committee was read and approved by the Committee.

A report of the Scholarship Committee was read and approved. Five students will receive awards.

Dr. Bandeian announced the members of the Ad Hoc Committee on Foundations for Medical Care. He also announced that their first meeting would be held on the 23rd of November.

As the report on Peer Review was a lengthy one and it was felt that the Committee should have the opportunity to study it further, it was voted to have it copied and sent out to members for study and be brought back to the Executive Committee in December.

The meeting was adjourned at 10:00 P.M.

The Grievance Committee met and heard four cases.

The meeting was adjourned at 10:45 P.M.

Ernest A. Byron, Jr.

* * * * * *

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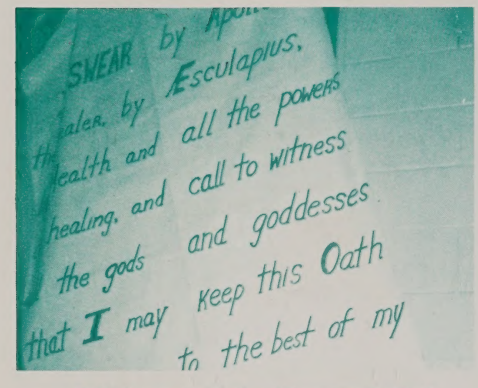
SWEAR by
Esculapius,
health and all the powers
healing, and call to witness
the gods and goddesses
that I may keep this Oath
to the best of my

Ball theme symbol — Hippocratic Oath.

Ball theme symbol — White Caps and Flowers with L. to R.: Mrs. David Blair and Mrs. Edward F. Caruso

Our Partner's Leaders, L. to R.: Mrs. Eugene Beauchamp, Jr., Chairman of the '71 Ball Committee; Mrs. John F. Griffin, President-Elect, WAHDMS, and Mrs. Edward F. Caruso, President of WAHDMS.

We just got here, L. to R.: Mrs. Sawyer E. Medbury, Past President of WAHDMS and Dr. Medbury.

Heady company, L. to R.: Mrs. Setrag A. Zacarian, Past President of WAHDMS and Dr. Setrag A. Zacarian, Secretary of HDMS.

Two heads together, L. to R.: Dr. Sheldon S. Goldberg, Executive Committee of HDMS and Mrs. Vivian M. Purdy, Executive Secretary of HDMS

Isn't it lovely, L. to R.: Dr. and Mrs. Howard M. Ledewitz

We think so too, L. to R.: Mrs. and Dr. William D. Kiss

Conviviality personified, L. to R.: Dr. Silvano Macchiaroli, Mrs. Sante M. Caldarola, Mrs. Peter Lynch and Dr. Peter Lynch.

We had a wonderful time, L. to R.: Mrs. and Dr. Victor Panitch.

We did too, L. to R.: Mrs. and Dr. Jacob B. Shammash.

In Memoriam

DONALD A. FORBES, M.D.

1937 - 1971

Dr. Donald A. Forbes of 321 Longhill St., Springfield, died at the Wesson Memorial Hospital on November 7, 1971.

Born in Ballymoney, Antrim, Northern Ireland, on July 12, 1937, Dr. Forbes graduated from Campbell College, Belfast, in 1954 and received his medical degree from the Queen's University, Belfast, Northern Ireland, in 1961. After serving an internship and residency at the Ards Hospital, Newtownards, Northern Ireland, he came to Springfield in 1964, where he served an internship at the Springfield Hospital Medical Center in 1964 and a residency at the Wesson Women's Hospital. Upon completion of his training in obstetrics and gynecology in 1967, Dr. Forbes engaged in the private practice of his specialty until his sudden demise.

Dr. Forbes served on the medical staffs of the Springfield Hospital Medical Center, the Wesson Women's Hospital, and the Wing Memorial Hospital. He was a fellow of the American College of Obstetricians and Gynecologists and a member of the MMS and the HDMS.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

In Memoriam

ARCHER L. HURD, M.D.

1901 - 1971

Dr. Archer L. Hurd of Springfield Road, Somers, Conn., died at his home on November 10, 1971.

Born in Somers, Conn., on May 6, 1901, Dr. Hurd graduated from Wesleyan College in 1922 and received his doctorate in medicine from the Harvard Medical School in 1927. After completing his postgraduate training, he came in 1933 to Springfield, where he engaged in the private practice of his specialty, namely, eye, ear, nose, and throat, until his demise.

Dr. Hurd served for many years on the medical staffs of the Springfield Hospital Medical Center and the Wesson Memorial Hospital. He was a member of the MMS and the HDMS.

To his family, his friends, and associates, deepest sympathy is hereby extended.

In Memoriam

JAMES G. BRUCE, M.D.

1904 - 1971

Dr. James G. Bruce, formerly of 252 Arcadia Blvd., Springfield, died at the Veterans Administration Hospital, St. Louis, Mo., on November 25, 1971.

Born in Claremont, N.H., on September 6, 1904, Dr. Bruce attended local schools in the Springfield area, Burlington, Vermont, as well as the University of Vermont. Moreover, he received his doctorate in medicine from the University of Vermont Medical School in 1928. He served his internship at the New Britain, Conn., General Hospital and later studied at the Hospital for Ruptured and Crippled Children in New York City. In 1931, he came to Springfield where he engaged in the private practice of medicine for the ensuing 38 years.

Dr. Bruce served for many years on the medical staff of the Springfield Hospital Medical Center. He was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and a member of the AMA, MMS, and HDMS. During World War II, he served with the U.S. Army Medical Corps being captured in the Philippines by the Japanese and held prisoner until 1946.

Deepest sympathy is hereby extended to his family and to his many friends and associates.

MARK YOUR CALENDAR NOW!

HDMS Meeting, February 1
HDMS Executive Committee Meetings January 18 and February 15
MMS Council Meeting, Boston, February 9
MMS Annual Meeting Boston, May 30, 31, and June 1
American College of Psychiatrists, Coronado, Calif., January 26-30
American Academy of Orthopedic Surgeons, Washington D.C., January 29-February 3
American Academy of Allergy, San Francisco, February 5-9
AMA Annual Meeting, San Francisco, June 18-22

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Correspondence . . .

T.B. Hospitalization

To the Editor:

This letter is to inform you about the recent change in in-patient care for patients with tuberculosis in your area. Previously, patients with tuberculosis from this area were treated at the Western Massachusetts Hospital. With the advent of effective chemotherapy, tuberculosis has now become an illness which, in many cases can be treated in a short term stay in selected general hospitals. Therefore, the Springfield Hospital Medical Center has agreed to admit patients with suspected or proven tuberculosis for a short term stay of up to 60 days.

Dr. Howard G. Turner, Jr., has been designated as our tuberculosis consultant and will be responsible for the in-patient care of tuberculosis patients at Springfield Hospital Medical Center. Patients requiring long term care for tuberculosis will still be treated at the Western Massachusetts Hospital.

In order to apply for admission of your patients with suspected tuberculosis to Springfield Hospital Medical Center, the standard application form must be filled out by you and sent to your local Board of Health for their approval. This form may be obtained at your local hospital or at your local Board of Health. If a delay is anticipated in obtaining the local Board of Health's signature, the patient may be admitted to Springfield Hospital after you have completed your part of the application.

We feel this added dimension to tuberculosis care will offer your patients optimum treatment with a minimum of in-patient care. If you have any questions regarding this change or the procedures involved, please contact us or Mario Wray, R.N., at the Western Regional Health Office in Amherst (545-2563). Dr. Turner can be reached at 787-4470.

Derek Robinson, M.D.
Division of Sanatoria and
Tuberculosis Control
Mass. Dept. of Public Health

Editor's Note: Local Boards of Health may be most reluctant to pay the hospital bill unless the above procedures are followed; since the State pays half the bill in the above circumstances and nothing otherwise.

Admissions to Northampton State Hospital

To the Editor:

New laws governing the admission of mentally ill patients to hospitals went into effect on November 1, 1971:

1. Only physicians licensed in the Commonwealth may sign the 10-day paper. New forms of the Department of Mental Health will be required. In order to insure the patient's acceptance, the physician must be qualified.*
2. The person must be mentally ill and

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there must be likelihood of serious harm:

A. A substantial risk of physical harm to the person himself as manifested by evidence of threats of, or attempts at suicide, or serious bodily harm.

B. A substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior, or evidence that others are placed in reasonable fear of violent behavior and serious physical harm to them, or

C. A very substantial risk of physical impairment or injury to the person himself as manifested by evidence that such person's judgment is so affected that he is unable to protect himself in the community and that reasonable provision for his protection is not available in the community.

3. Admissions will be between 8 A.M. and 4 P.M. If the patient is already in a hospital, a hospital emergency room, a nursing home, or a rest home, there is no valid reason for sending him at hours other than those stipulated.

4. The Northampton State Hospital will continue to serve the residents of Western Massachusetts, but it will also comply strictly with the new laws.

Harry Goodman, M.D.
Superintendent
Northampton State Hospital

* DEFINITION OF QUALIFIED PHYSICIAN – (Ref. M.G.L. ch, 123, S. 1)

1. Any physician practicing medicine in the community and meeting the qualifications established hereunder may apply for appointment to the courtesy staff of a Department of Mental Health or private facility which admits patients under M.G.L. ch. 123, s.12, and for designation as a "qualified physician".

a. For designation as a "qualified physician" to authorize admissions only to such facility for up to 10 days under said s. 12, such members of the courtesy staff shall be fully licensed to practice medicine under Massachusetts law, and

i. shall be certified or eligible to be certified by the American Board of Psychiatry and Neurology; or

ii. shall have had three years experience on the staff of a public or private mental health facility in the examination and treatment of mentally-ill persons; or

iii. shall have had five years experience in medical practice, which has included the care and treatment of mentally-ill persons.

b. The superintendent or director of the facility shall notify the physician in writing of his appointment to the courtesy staff of the facility and of his designation as a "qualified physician" for the purposes of s. 12 admissions. Appointments shall be made and renewed annually.

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